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Medical

PREVENTIVE HEALTH ASSESSMENT

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This instruction has been revised to reflect changes in the manning and organizational structure of the Preventive Health Assessment (PHA) cell. In addition, deployment health assessments have been aligned with the current PHA process. This instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*; AFPD 10-2, *Readiness*; AFPD 40-1, *Health Promotion*; and Health Affairs Policy Memo 06-006, *Periodic Health Assessment for Active Duty and Selected Reserve Members*. This instruction augments Air Force Instruction (AFI) 10-250, *Individual Medical Readiness*; AFI 40-102, *Tobacco Use in the Air Force*; and AFI 48-123, *Medical Examinations and Standards.* It establishes procedures, requirements, and recording and medical standards for Air Force (AF) periodic/preventive health assessments (PHAs), and applies to all active duty (AD) Airmen, Air National Guard (ANG) members, and Air Force (AF) Reservists.

This publication requires the collection and maintenance of information protected by the *Privacy Act of 1974* (*Title 5 United States Code*, Section 552a). *Title 10 United States Code*, Sections 8013 and 8067(d), and Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons*, as amended by Executive Order 13478, *Amendments to Executive Order 9397, Relating to Federal Agency Use of Social Security Numbers authorize the collection and maintenance of records prescribed in this publication*. Forms affected by the Privacy Act (PA) must have an appropriate PA statement. System of records notice F044 AF SG E, *Medical Record System,* applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AF Manual (AFMAN) 33-363, *Management of Records,* and disposed of in accordance with (IAW) the AF Records Disposition Schedule located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**. All records should also be maintained IAW AFI 41-210, *Patient Administration Functions*. Comments and suggestions

pertaining to this instruction should be routed through the appropriate functional's chain of command and forwarded to the Office of Primary Responsibility (OPR) on AF Form 847, *Recommendation for Change of Publication* (AF/SG3PM, 1500 Wilson Blvd., Suite 1600, Arlington, VA 22209).

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Chapter 1

OVERVIEW, ROLES, AND RESPONSIBILITIES

1.1. Overview of the PHA. This instruction provides guidance and procedures for the AF Preventive Health Assessment (PHA) program, also known as the *Periodic* Health Assessment (PHA) program in the Air Guard and AF Reserves. The intent of the PHA program is two-fold: to provide evidence-based, cost-effective preventive health services and to identify and document potential duty-limiting conditions. Unless otherwise stated, this instruction applies to all Airmen, including the Guard and Reserve components.

1.2. Roles and Responsibilities.

1.2.1. **AF Surgeon General (AF/SG).** The OPR for the AF PHA program. Ensures medical resources are planned, programmed, and budgeted to meet PHA requirements.

1.2.2. **Assistant Surgeon General for Healthcare Operations (AF/SG3).** OPR for instructions and guidance for PHA program execution.

1.2.2.1. Provides instructions and guidance ensuring Airmen meet Department of Defense (DoD) PHA requirements.

1.2.2.2. Represents the AF at the DoD Force Health Protection Council and Defense Health Board who advise the Service SGs and DoD on PHA instructions and guidance.

1.2.2.3. Approval authority for Major Command (MAJCOM), Direct Reporting Unit (DRU), and Air Reserve Component variations to this instruction.

1.2.3. **Air Force Medical Support Agency (AFMSA).** Develops and updates PHA instructions and guidance in coordination with Medical Treatment Facilities (MTFs), MAJCOMs, and the AF/SG.

1.2.4. Air Force Medical Operations Agency (AFMOA).

1.2.4.1. Reviews/updates the *PHA Guide* and PHA business rule algorithms contained within PHA and Individual Medical Readiness (PIMR) and the AF Web-based Health Assessment (Web HA) at least yearly.

1.2.4.2. Approves and, when necessary, develops PHA-related patient education materials.

1.2.4.3. Maintains and updates the PHA Knowledge Exchange (Kx) website (ref. 2.1.).

1.2.4.4. Identifies and defines clinical requirements to enhance information management tool functionality in support of annual PHA process.

1.2.5. **Air Force Surgeon General's Modernization Directorate (AF/SG6).** Develops, deploys, maintains, and updates clinical support tools including the PIMR application and the AF Web HA.

1.2.6. MAJCOM or DRU Commander (CC).

1.2.6.1. OPR for developing instructions and processes to ensure Airmen assigned to geographically-separated units (GSUs) meet PHA requirements as defined in 2.5.

Coordinates the implementation of instructions and publications with AF/SG3. For the purposes of this AFI, a GSU is broadly defined as any organization (military installation, embassy, university, etc.) in which Airmen assigned to that organization are not in close proximity with the Force Health Management Element (FHME) responsible for administering their PHAs. What entails "close proximity" shall be locally defined.

1.2.6.2. Monitors and reviews the PHA status of geographically-separated Airmen or delegates this responsibility to the GSU/CC.

1.2.6.3. Appoints Unit Health Monitors (UHMs) at GSUs or delegates this responsibility to the GSU/CC.

1.2.6.4. Ensures subordinate GSU/CCs comply with delegated duties and requirements in 1.2.9.

1.2.7. **Air Reserve Component (ARC)**

1.2.7.1. The AF Reserve Command Surgeon (AFRC/SG) is the OPR for PHA instructions and guidance for the Air Reserve including Individual Ready Reservists and Individual Mobility Augmentees (IMAs). AFRC/SG will maintain and update the *AFRC PHA Guide* and modify AFMOA-developed PHA business rules to meet AFRC-specific requirements as needed and permitted by this AFI. AFRC variations to this AFI must be approved by SG3 (see 1.2.2.3.).

1.2.7.2. The Air Surgeon of the Air National Guard (ANG/SG) is the OPR for PHA instructions and guidance for ANG members. ANG/SG oversees the modification of AFMOA-developed PHA business rules to meet ANG-specific requirements as needed and permitted by this AFI. ANG variations to this AFI must be approved by AF/SG3 (see 1.2.2.3.).

1.2.8. Air Force Installation CC.

1.2.8.1. Establishes a command expectation that unit CCs and individual Airmen will meet PHA requirements IAW this instruction and AFI 10-250, *Individual Medical Readiness*.

1.2.8.2. Directs the AF Military Personnel Flight (MPF) to add PIMR/PHA currency status to the virtual MPF permanent change of station (PCS) out-processing checklist. Checking PHA status during out-processing is not required when PCSing from remote (short tour) AF installations or other geographically-separated locations without local AF MTF support.

1.2.8.3. In Joint Basing and tenant unit situations where a Sister Service is the lead service, the responsibilities in section 1.2.8. fall to the senior-ranking AF member or his/her delegate.

1.2.9. Air Force Unit CC.

1.2.9.1. Establishes a command expectation that individual Airmen will meet PHA requirements IAW this instruction, AFI 10-250, and AFMAN 36-8001.

1.2.9.2. Appoints a UHM.

1.2.9.3. Reviews Individual Medical Readiness (IMR) unit reports at least monthly and ensures Airmen comply with PHA requirements. Real-time reports are available at **https://asims.afms.mil/webapp/login_unit.aspx**.

1.2.9.4. Ensures each Airman has a Common Access Card (CAC) and access to a CAC reader IAW AFI 36-3026_IP, *Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel*. The AF Web HA and the “"Medical Readiness-Deployment Health" link on the AF Portal (under “Fitness and Health”) require CAC-enabled Web access.

1.2.10. **Unit Health Monitor (UHM).** Notifies Airmen of due/overdue PHA and IMR requirements, monitors PHA and IMR status via the Web Aeromedical Services Information Management System (ASIMS) application in coordination with unit CCs and the MTF FHME, and assists Airmen with the coordination of follow-up PHA requirements. Real-time reports are available at **https://asims.afms.mil/webapp/login_unit.aspx**. See 2.5.2.1. for the definition of “reporting MTF.”

1.2.11. Individual Airman.

1.2.11.1. Completes the AF Web HA or AFMOA-approved paper self-report status questionnaire. Keeps PHA appointments, follow-up appointments, and other PHA-related suspenses.

1.2.11.2. Takes personal responsibility for their IMR requirements by accessing the "Fitness & Health," then "Medical Readiness-Deployment Health" link on the Air Force Portal, and addresses deficiencies. The site can also be accessed directly from any computer provided they have a valid CAC card and a CAC reader, at **https://asims.afms.mil/webapp/MyIMR.aspx**.

1.2.12. **Medical Treatment Facility CC (MTF/CC), including ANG Medical Group CC (ANG MDG/CC) and Reserve Medical Unit CC (RMU/CC).** OPR for the PHA program at the installation level. The abbreviation “MTF” will be used broadly in this instruction to identify all component medical facilities, groups, and units (e.g., RMUs).

1.2.12.1. Ensures MTF capabilities and appointment access are adequate to meet PHA requirements and provide sufficient follow-up care IAW TRICARE access standards.

1.2.12.2. Monitors and enforces MTF compliance with this instruction.

1.2.12.3. Advocates, promotes, and is the primary liaison for PHA issues at the installation/Wing level.

1.2.12.4. Plans, programs, budgets, and procures PHA supplies and equipment.

1.2.12.5. Maintains and resources a FHME (AD, non-GSU MTFs only). Ensures the FHME is manned according to this instruction. (ref. 1.2.18.2.)

1.2.12.6. Ensures Airmen in the Personnel Reliability, Biological Personnel Reliability, or Presidential Support Programs (PRP/BPRP/PSP) have access to the AF Web HA within the MTF (e.g., at dedicated AF Web HA computer stations). Ensures the results are reviewed at the appropriate level indicated by AF Web HA responses and the Airman’s PRP/BPRP/PSP status is assessed by a Competent Medical Authority (CMA) before leaving the MTF IAW DoD 5210.42-R_AFMAN 10-3902, *Nuclear Weapons*

Personnel Reliability Program (PRP), DoD Instruction (DoDI) 5210.89_AFI 10-3901, *Minimum Security Standards for Safeguarding Biological Select Agents and Toxins,* and AFI 31-501, *Personnel Security Program Management.*

1.2.12.7. Ensures MTF AF Web HA computer stations meet patient and information privacy and security requirements.

1.2.12.8. Assigns a Group Practice Manager (GPM) and Health Care Integrator (HCI) to assist the FHME and patient care teams in managing appointment access and projecting demand for PHAs and clinical preventive services (CPS). This requirement does not apply to ARC units.

1.2.12.9. Ensures FHME staff and patient care team providers have adequate time and resources to effectively accomplish PHA duties. This includes, but is not limited to, dedicated clinic time to administer PHAs.

1.2.13. **Chief of Aerospace Medicine (SGP).** MTF OPR for the clinical management of the PHA program.

1.2.13.1. Provides oversight of the clinical aspects of the PHA program under the FHME of Public Health.

1.2.13.2. Develops, in coordination with the Chief of the Medical Staff and Public Health, MTF instructions and procedures to implement PHA-associated clinical practice guidelines (CPGs) and quality assurance processes.

1.2.13.3. Provides profile, Medical Evaluation Board (MEB), Review in Lieu of MEB (RILO), and Duty Limiting Conditions (DLC) expertise and oversight to the patient care clinics. Orients and trains providers on profile, MEB, RILO, and DLC processes.

1.2.13.4. Develops Executive Committee of the Medical Staff (ECOMS)-approved PHA protocols and standing orders in coordination with the SGH, Chief of Nursing Services, Public Health Flight Commander and senior enlisted functionals to enable clinical support personnel to independently order and schedule CPS on behalf of providers IAW the Career Field Education and Training Plan (CFETP).

1.2.13.5. The SGP or the MDG/CC's designee will manage the overarching clinical operations of the FHME (contrast with 1.2.16.1.).

1.2.14. **Chief of the Medical Staff (SGH)**

1.2.14.1. In coordination with the SGP and Public Health, ensures PHA-associated CPS and counseling services are consistently and uniformly applied throughout the MTF.

1.2.14.2. Assists the SGP and Public Health in developing MTF instructions and procedures to implement PHA-associated CPGs and quality assurance processes.

1.2.14.3. Assists the SGP in developing ECOMS-approved PHA protocols and standing orders to enable clinical support personnel to independently order and schedule CPS on behalf of providers.

1.2.14.4. Oversees credentialing and privileging of professional staff providing PHA services.

1.2.14.5. Implements ECOMS-approved processes ensuring appropriate clinical follow-up of PHA-generated laboratory results, consults, and referrals.

1.2.14.6. Provides guidance and oversight of PHA clinical peer-review processes.

1.2.14.7. Oversees development and dissemination of PHA-related patient education materials. PHA-related patient education materials not otherwise approved by AFMOA must be approved by the ECOMS.

1.2.15. **Group Practice Manager (GPM) and Health Care Integrator (HCI).** Support the FHME and patient care teams in managing appointment access and projecting PHA and CPS demand (ref. 1.2.12.9.). Ensures efficiency in PHA appointment scheduling (e.g., FHME has direct access to patient care team appointment schedules for making provider appointments associated with PHAs).

1.2.16. **Patient Care Team (e. g., Family Health Team, Flight and Operational Medicine Clinic).**

1.2.16.1. Provides oversight of FHME activities as they pertain to specific individual patient issues (contrast with 1.2.13.5.).

1.2.16.2. Provides one-on-one PHA appointments with credentialed providers IAW this instruction (ref. 2.2.6.1), PHA business rules, and/or other clinical criteria.

1.2.16.3. Provides indicated CPS, counseling, screening 12-lead electrocardiograms, and follow-up care for enrolled Airmen and other service members who receive clinical PHA services from the patient care team.

1.2.16.4. Clinically manages FHME-generated laboratory results of enrolled Airmen and other service members who receive clinical PHA services from the patient care team.

1.2.16.5. Completes required DLC determinations and MEB and RILO actions/narratives.

1.2.16.6. Uses GPM-forecasted fluctuations and surges in PHA appointment demand and HCI-forecasted demand for CPS and follow-on appointments to judiciously manage staff leaves, temporary duty (TDY) assignments, etc. ensuring there is sufficient clinic staffing to handle projected demand.

1.2.16.7. Ensures the PHA and IMR status of Airmen are checked using PIMR at each primary health care visit at an AF MTF. Due/overdue IMR requirements and recommended CPS should be addressed (performed, ordered, referred, etc.) during that visit.

1.2.16.8. Informs MTF leadership of clinic personnel and resource needs.

1.2.17. Public Health Flight Commander (SGPM).

1.2.17.1. Oversees and coordinates the administration of the PHA program under the FHME.

1.2.17.2. Ensures personnel involved in FHME processes are adequately trained and oriented.

1.2.17.3. Ensures PHA requirements, including base-specific requirements, are briefed and medical records are reviewed at PCS in-processing (e.g., Medical Right Start) to ensure these requirements are up-to-date.

1.2.17.4. Arranges and coordinates PHA briefings and training at appropriate MTF venues including ECOMS, professional staff meetings, and ancillary staff in-service training.

1.2.17.5. Informs MTF/CC of FHME personnel and resource needs through the appropriate squadron commander/SGP.

1.2.17.6. Actively monitors and tracks administrative performance measures (e.g., timely notification of patient care team of critical/priority results, close out of PHAs).

1.2.17.7. Supervises the FHME.

1.2.18. Force Health Management Element (FHME).

1.2.18.1. Acts as the MTF OPR for the administrative management of the PHA program. ARC units are not required to establish FHMEs (ref. 1.2.18.13.).

1.2.18.2. Minimum FHME staffing requirements will include:

1.2.18.2.1. Three (3) Public Health Technicians (4E0X0) or civilian equivalent for the first 5000 enrolled service members. One of these 4E0X0s must be at least a level 7 (or equivalently trained and experienced supervisory-level civilian).

1.2.18.2.2. One (1) additional 4E0X0 (or civilian equivalent) is earned for the next 1 to 2500 enrolled service members (5001-7500 enrolled service members). For example, an FHME responsible for 6000 enrolled service members will be allotted four 4E0X0s.

1.2.18.2.3. One (1) additional 4E0X0 (or civilian equivalent) is earned when service member enrollment exceeds 7500. For example, an FHME responsible for 8000 enrolled service members will be allotted five 4E0X0s.

1.2.18.2.4. FHME staffing will also reflect additional workload numbers accrued from administering the PHAs of non-enrolled, geographically-separated Airmen, student populations, ARC Airmen, as well as any Sister Service PHA responsibilities (ref. 2.3.18.1., 2.5.5., and 2.6.). Historical or projected PHA workload numbers accrued from these populations may be used to justify increased FHME staffing.

1.2.18.3. FHME duties will be distributed among the technicians by the senior technician.

1.2.18.4. FHME will manage the administrative tracking, notification, processing, and quality control of PHAs. FHME is not required to track ARC or Sister Service PHAs or notify these members that PHAs are due unless specific local processes to conduct these functions are set up with the ARC or Sister Services.

1.2.18.5. FHME will use GPM-forecasted fluctuations and surges in PHA appointment demand due to PCS and deployment cycles to judiciously manage staff leaves, TDYs, etc. to ensure there is adequate FHME staffing to handle projected PHA demand.

1.2.18.6. FHME will track Airmen who have failed to meet PHA suspenses or who have excessive short-notice cancellations or missed appointments for scheduled services, and forward this information to their respective UHMs/unit CCs. What constitutes "excessive" short-notice cancellations or missed appointments will be determined at the installation or MTF level.

1.2.18.7. Using the AF Web HA computer application, FHME will generate a "Multiple Patient Report" each duty day and address findings IAW this AFI, clinical circumstances, and the PHA business rules (ref. 2.3.1.3.).

1.2.18.8. FHME will ensure all PRP/BPRP/PSP personnel seen for PHAs are referred to a PRP/BPRP/PSP monitor for proper disposition IAW DoD 5210.42-R_AFMAN 10-3902, DoDI 5210.89_AFI 10-3901, and AFI 31-501.

1.2.18.9. Based on PHA business rules and clinical guidance from the patient care teams, FHME will schedule required appointments with patient care teams and direct patient to ancillary services (e.g., Health and Wellness Center, lab, immunizations).

1.2.18.10. FHME will order necessary PHA and IMR labs as directed by IMR regulations, PHA business rules, and ECOMS-approved business rule modifications. Patient care clinics are responsible for follow-up of lab results. ARC medical assets (ANG MDG and RMU) are responsible to ensure proper follow-up of ARC-ordered labs.

1.2.18.11. Clinical interventions within FHME will be limited to directing follow-up care, (to the provider, nurse, Health and Wellness Center, etc.), brief counseling and education, distributing AFMOA- or ECOMS-approved, PHA-related, patient education handouts (ref. 2.3.8.), weight, height, blood pressure, and vision assessment measurements (via Snellen Eye Exam). All clinical interventions within FHME will be limited to those prescribed by the 4E CFETP and AFMOA-/ECOMS-approved protocols.

1.2.18.12. FHME will document all patient interventions, including attempts to contact member, in the medical record (e.g., the DoD electronic medical record, Armed Forces Health Longitudinal Technology Application or AHLTA).

1.2.18.13. FHME will review PIMR/PHA status of individuals inprocessing (newcomers) and outprocessing to the installation to ensure their PHA, IMR, occupational health, and deployment health assessment requirements are current.

1.2.18.13.1. At inprocessing, FHME will also conduct an initial medical records review (includes hard copy records and AHLTA) to identify possible mobility or duty restricting limitations. FHME will forward records requiring further evaluation (e.g., possible AF Form 469 actions) to the Medical Standards Management Element.

1.2.18.13.2. At outprocessing, FHME will forward records requiring further medical clearance action to MSME (ref. 1.2.19.).

1.2.18.14. For ARC units, in lieu of FHMEs, the following surrogates will be used:

1.2.18.14.1. Air Reserve. The Air Reserve Technician (ART) Team within the RMU will perform FHME-like functions within Reserve units.

1.2.18.14.2. ANG. Health technicians within the ANG/MDG will perform FHME-like functions within Guard units.

1.2.19. **Flight and Operational Medicine (FOM) Clinic, Medical Standards Management Element (MSME)**

1.2.19.1. The MSME within FOM will administer mandatory medical clearances for overseas PCS (AD member only), professional military education (PME), and training/retraining assignments. As a part of the clearance process, MSME will ensure PHA currency at the time of the clearance and ensure PHAs will be current throughout PME and training/retraining assignments, and during projected overseas PCS transitions.

1.2.19.2. Should the member require a PHA, MSME will send the member to FHME to complete the required PHA. In some cases, PHAs earlier than normally scheduled may be necessary (ref. 2.2.2., 2.2.4., 2.2.5., and 2.2.8).

Chapter 2

PHA PROGRAM OPERATIONS

2.1. PHA Kx Website. A website for PHA assistance and resources is available at the AF Medical Service Knowledge Exchange (Kx): **https://kx.afms.mil/pha**. Resources available at this website include contact information for PHA/PIMR expertise, PHA business rules, the *PHA Guide,* the *AFRC PHA Guide,* other ANG- and Reserve-specific guidance, and CPS resources. Providers, nurses, and technicians involved in the PHA process will familiarize themselves with this website and subscribe to this website for email notices of website updates.

2.2. Periodicity of the PHA.

2.2.1. IAW Health Affairs Policy Memo, 06-006, the PHA is required annually. This requirement supersedes previous physical exam policy. This policy is distinct from IMR policy because it also applies to *all* Airmen, including those who are non-deployable and may be exempt from IMR standards.

2.2.2. PHAs become due (turn "yellow") 12 months (366 days) from the last PHA completion date. Once the PHA becomes due, there is a 90-day "yellow" window to accomplish the PHA before the PHA "goes red" and the unit is penalized on their PHA IMR score. The PHA is green for 365 days; turns yellow (due) on day 366, and turns red (overdue) 90 days later on day 456. An AF Form 1042, *Medical Recommendation for Flying*, for personnel in special operational duty status, issued in conjunction with PHAs will be valid for the entire green and yellow periods (12 months plus 90 days; 455 days total). It is **not** the intent of the 90-day yellow period to establish a *de facto* 15-month PHA requirement. "PHA due" notices will be forwarded by the UHM to unit Airmen during the first month of the 90-day window. The 90-day window allows more-than-adequate time to schedule/accomplish PHAs and other requirements for AF Form 1042s, accounting for leaves, TDYs, and other mission requirements. PHAs performed just prior to the 15-month cut-off should be the rare exception and not the rule.

2.2.3. The National Defense Authorization Act (NDAA) 2010, Sec 708 and DoD Health Affairs Policy require deployers to receive four deployment resiliency assessments (DRAs) at specified time intervals. For those personnel requiring DRAs, the third and fourth DRAs will be conducted concurrently with the PHA. As such, these PHAs will be accomplished IAW DRA scheduling and not as required by 2.2.2. above.

2.2.4. Newly accessed Airmen will have their first PHA accomplished during the first 180 days of their first permanent duty assignment. Upon in-processing, their PHA will be considered to be in a "yellow" status as defined in 2.2.2. and turn "red" on day 181 if the PHA is not completed.

2.2.5. PHAs will not be completed any earlier than 30 days before the PHA due date (60 days for ARC Airmen) except in the following situations: as required to coordinate with DRAs, in cases of in-residence PME, retraining/training assignments, PCS to remote locations and GSUs (as defined in 1.2.6.1.), deployments, and prolonged TDYs; as permitted by MAJCOM/SGPA or AFMSA/SGPA AF Form 1042 waivers; in cases of ANG general officer promotions; and as needed to accommodate mandatory occupational and environmental health medical surveillance exams (OEH MSE) (ref. 1.2.19.1., 2.2.3., 2.2.7.,

2.2.8., 2.2.9., 2.2.9.3., 2.2.10.4., 2.3.9. for specifics regarding these exceptions). The element (FHME or MSME) servicing the patient will identify the need for an early PHA.

2.2.6. One-on-one provider PHA appointment criteria.

2.2.6.1. Airmen will have a one-on-one preventive health visit with a credentialed provider at least once every three years. One-on-one provider PHA visits, as well as any non-dental, prevention-focused, provider visit accurately coded with a preventive evaluation and management (E/M) code (e.g., E/M codes 99385-86, 99395-96, 99401-04) will satisfy this requirement. It is important providers accurately code preventive visits and refrain from miscoding visits that are clearly administrative in nature (e.g., PCS clearances, etc.) with preventive E/M codes (ref. PHA Kx website as in 2.1.).

2.2.6.2. Additional one-on-one provider PHA appointments may be necessary under the following circumstances:

2.2.6.2.1. A patient may request a provider appointment in conjunction with their PHA visit. FHME will offer the option for a provider appointment to all patients when scheduling the PHA visit, and state whether the appointment is optional or mandatory.

2.2.6.2.2. As required per PHA business rules.

2.2.6.2.3. A provider appointment may be directed by the Airman's patient care team (or surrogate) after AF Web HA and PIMR review. The patient care team, led by the provider, will review critical/priority/routine health risk assessment findings and assess if further evaluation is required.

2.2.6.3. Provider appointments will be scheduled in conjunction with the FHME PHA visit (back-to-back) to minimize the patient's time spent at the MTF.

2.2.6.4. MAJCOMs and MTFs may modify business rules to require more frequent provider PHA visits but may not waive or alter AFI requirements to reduce the frequency of these visits. PIMR and AF Web HA software will not be modified to accommodate MAJCOM-specific or MTF-specific business rules.

2.2.6.5. Every PHA for Airmen requiring an AF Form 1042 will include a PHA appointment with a flight surgeon.

2.2.7. Airmen requiring an AF Form 1042 will have their flight physicals done in conjunction with their PHAs. As such, PHA frequency and timing, detailed in sections 2.2.2., 2.2.3., 2.2.5., 2.2.8., and 2.2.9., also apply to Airmen requiring AF Form 1042s. MAJCOM/SGPA- or AFMSA/SGPA-approved extensions/waivers applicable to flight physicals will also apply to PHAs.

2.2.8. Airmen PCSing from an AF installation to a remote location or another location without local AF MTF FHME support will have a PHA within 60 days of PCS even if this means accomplishing a PHA earlier than the originally scheduled due date. This is necessary to minimize the administrative and logistical burden of performing PHAs at locations without local AF MTF FHME assets.

2.2.9. PHAs due around deployments. PHAs do not need to be accomplished on deploying Airmen as long as the PHA is current (within 365 days of the last recorded PHA) on the

projected required delivery date. During deployments and for three months following deployment, Airmen will not be monitored for PHA currency and will be considered exempt from PHA requirements during this deployment window. This exemption also applies to Flying/Special Duty Physicals and OEH MSEs. Although Airmen will not be monitored for PHA/OEH MSE/Flying/Special Duty Physicals while deployed, Airmen should not deploy with due/overdue examinations, IMR requirements, or other requirements for these programs. Upon redeployment, Airmen will be required to update their due/overdue PHA/OEH MSE/Flying/Special Duty Physicals within 90 days of return.

2.2.9.1. If the AF Form 1042 is due to expire during the deployment, FOM will accomplish a new 1042 with the extended expiration date (redeployment date + 90 days). If 1042 holders have a waiver that will expire during the deployment, FOM will request a waiver extension to the same date through the granting waiver authority. The waiver authority may grant the waiver extension to be concurrent with the AF Form 1042 (redeployment date + 90 days) unless health, safety and/or mission completion would be compromised.

2.2.9.2. For OEH MSEs that will become due/overdue during deployment, FHME will make an entry in the medical record (AHLTA preferably) to document the reason why the OEH MSE will not be accomplished IAW AFI 48-145, *Occupational and Environmental Health Program* and provide an estimated completion date. Use this instruction as a reference.

2.2.9.3. Although not required, PHAs may be completed early for deploying Airmen as determined appropriate by FHME.

2.2.9.4. ARC members whose PHA is current (within 365 days of last recorded PHA) will receive a full medical record review prior to deployment.

2.2.10. ARC.

2.2.10.1. ARC members will have annual PHAs conducted using AFMOA-developed business rules. As required, these business rules will be modified to meet special AFRC and ANG requirements (subject to 1.2.2.3.).

2.2.10.2. ARC units will process PHAs using FHME surrogates detailed in 1.2.18.13.

2.2.10.3. ARC members not requiring AF Form 1042s will have a one-on-one provider PHA appointment at the following minimum frequency: ANG at least every 5 years, and AFRC at least every 3 years. ARC members requiring AF Form 1042s will have a one-on-one provider PHA annually in conjunction with their flight physical.

2.2.10.4. ANG officers being considered for promotion to general officer or promotion within the general officer ranks must undergo a PHA within 6 months of the recognition board. Forward copy of the PHA to: NGB/SGPF GO EAD REVIEW at **ngb.sggoeadreview@ang.af.mil.**

2.2.10.5. Expired PHAs in ARC members.

2.2.10.5.1. Reservists with expired PHAs will be referred to their CCs IAW AFI 36-2254 Vol.1 and processed IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Member*s or involuntary transferred to

the Individual Ready Reserve in accordance with AFI 36-2115, *Assignments Within the Reserve Components.*

2.2.10.5.2. ANG members with expired PHAs will be referred to their CC and processed IAW AFI 36-3209.

2.2.10.5.3. ARC members involuntarily ordered to AD will not delay such action because of an expired PHA. For those ARC personnel with expired PHAs, PHAs will be accomplished within the first 60 days of AD. Members will not deploy with expired PHA or IMR requirements per 2.2.9.

2.2.10.6. Service members must have a current PHA prior to transfer to an ARC unit. The PHA must remain current for the first 90 days upon accession to the ARC unit. Prior to accession to ARC, service members with potentially disqualifying conditions IAW 48-123, *Medical Examinations and Standards* must be evaluated for fitness for duty (fast track or MEB).

2.3. PHA Requirements.

2.3.1. Completion of the AF Web HA.

2.3.1.1. IAW Health Affairs Policy Memo, 06-006, the PHA will use a self-report health status tool. The AF's self-report health status tool, the AF Web HA, will be used for AD and ARC PHAs. In situations where the AF Web HA is unavailable, the SF 507 template available in PIMR can be used in lieu of the AF Web HA. Airmen completing AF Web HA will not be required to complete a redundant paper self-report status questionnaire.

2.3.1.2. For deployers, the DD Form 2795, DD Form 2796, or DD Form 2900 can be used in place of the AF Web HA as the patient self-report health status tool if completed within 60 days of the FHME appointment.

2.3.1.3. The AF Web HA must be completed no earlier than 30 days (60 days for ARC and deployers as in 2.3.1.2.) prior to the FHME appointment.

2.3.1.3.1. PRP/BPRP/PSP personnel are required to complete the AF Web HA at an MTF computer with results immediately reviewed and addressed by a Competent Medical Authority (CMA) IAW DoD 5210.42-R_AFMAN 10-3902, DoDI 5210.89_AFI 10-3901, and AFI 31-501. If patient results are not immediately available via the "Multiple Patient Report," the CMA will use the AF Web HA "AHLTA COPY AND PASTE REPORT" to determine appropriate PRP/BPRP/PSP disposition. As deemed necessary or required by the CMA or other governing instructions, raw AF Web HA data may be used in lieu of the "Multiple Patient Report" or "AHLTA COPY AND PASTE REPORT." Ref. 2.5.4.2. for special PRP/BPRP/PSP provisions at GSUs.

2.3.1.3.2. All other Airmen are strongly encouraged to complete the AF Web HA prior to coming to the MTF for their PHA appointment. Airmen not completing the AF Web HA prior to coming to the MTF may do so at a designated MTF computer station. Airmen who elect to complete their AF Web HA at the MTF will do so such that it is completed at least 30 minutes prior to the appointment show time. Due to Unit Training Assembly (UTA) time constraints, ARC members **must** complete their AF Web HA before their PHA appointment.

2.3.1.4. FHME will check the AF Web HA "Multiple Patient Report" each duty day for critical, priority, and routine results. These results will be handled in the following manner:

2.3.1.4.1. AF Web HA results will be queued up; critical results addressed first, followed by priority results. Critical findings must be addressed within one duty day. Priority results must be addressed within three duty days. See 2.3.18.3. for ARC variation.

2.3.1.4.2. The AHLTA telephone consult function will be used by FHME to address critical and priority findings. FHME technicians will initiate the telephone consult in AHLTA, flag it as "high priority," and immediately forward it to the patient care team for review.

2.3.1.4.3. The patient care team nurse (or ARC health technician), with provider oversight, will review critical and priority PHA telephone consults, obtain necessary additional clinical information via telephone or an in-person visit, and document the encounter in AHLTA. All attempts at patient contact will be documented. The patient care team will forward telephone consults to the provider (or surrogate) for final review, disposition, and signature. The date/time the Airman electronically submits his/her AF Web HA and the date/time the patient care team provider signs the critical or priority PHA telephone consult will be used to determine one- and three-duty day suspense compliances for critical and priority findings respectfully.

2.3.1.4.4. Once critical and priority results have been appropriately addressed, the balance of AF Web HA results and the other PHA requirements may be accomplished at that time (or an appointment made) and completed at a later time per 2.3.1.3.6. Future follow up appointments should not preclude the closing out of the member's PHA.

2.3.1.4.5. Program effectiveness and compliance will be assessed through the peer review process and compliance metrics.

2.3.1.4.5.1. The MTF peer review process will include provider assessment, disposition, documentation, and referrals related to PHA. Quarterly reviews of PHA peer review processes will be reported to Executive Committee.

2.3.1.4.5.2. Program compliance metrics for the administrative components of the PHA program will include, at a minimum, the time windows for addressing critical and priority suspenses (e.g., timely notification of patient care team).

2.3.1.4.6. PHAs with routine AF Web HA results will undergo a records review by FHME to determine the need for further follow up/tests and referral to the patient care team via standard appointing systems, documented using AFMOA-approved AHLTA templates for final disposition.

2.3.2. FHME will review PIMR for due/overdue IMR requirements and direct the patient to the appropriate clinic/laboratory to complete any requirements.

2.3.3. FHME will review the medical record (paper and AHLTA) for interval medical and surgical history, family history, and currency of clinical preventive services.

2.3.4. FHME will identify and schedule required CPS as directed by PHA business rules. The patient care team is responsible for follow-up of any FHME scheduled services. The business rules reflect current best practice and are regularly updated to reflect new recommendations and evolving standards of practice (ref. 2.1.).

2.3.4.1. The *United States Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services* is the main source of guidance for CPS business rules (**http://www.preventiveservices.ahrq.gov**). Clinicians must be familiar with USPSTF recommendations (ref. 2.1.).

2.3.4.1.1. A USPSTF category A or B recommendation has at least good or fair evidence that the CPS improves important health outcomes and benefits outweigh harms in routine patient populations. The business rules stipulate category A and B recommendations will be offered to all eligible patients.

2.3.4.1.2. A USPSTF category C recommendation has at least moderate certainty the net benefit of the CPS is too small to justify a recommendation in routine populations. A USPSTF Category D recommendation has moderate or high certainty that the CPS has no net benefit or that the harms outweigh the benefits. MTFs will not offer CPS with Category C or D recommendations as a part of routine local MDG PHA instructions.

2.3.4.1.3. A CPS with a USPSTF "I statement" has insufficient evidence to assess the balance of benefits and harms of the CPS in routine populations due to insufficient, poor quality, or conflicting evidence. Some circumstances may warrant MTFs appending the business rules to offer "I statement" services. MTFs may incorporate ECOMS-approved additions of these services into local MDG PHA instructions.

2.3.4.2. Individual providers may deviate from the business rules and/or provide additional or alternative CPS to individual patients as indicated by special clinical circumstances. Rationale for these deviations must be documented in the medical record.

2.3.5. FHME will ensure there has been an officially-measured blood pressure within the past year (for ANG, within 5 years). Officially-measured blood pressures entail clinical measurements (e.g., medical or dental clinic). As needed, the FHME will take blood pressure measurements. PHA business rules for blood pressure screening and managing elevated blood pressures are based on the most recent *Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure Report* (**http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm**).

2.3.6. FHME will ensure there has been an officially measured weight within the past year and an officially measured height (for ANG, within 5 years). Official measurements are limited to clinic- and fitness cell-obtained measurements. Self-reported heights and weights will not be used. As required, FHME will measure the Airman's height and/or weight. Body Mass Index (BMI) is automatically calculated in PIMR and results will be manually transcribed into AHLTA. BMIs will be managed according to PHA business rules. FHME will conduct visual assessments (via Snellen Eye Exam) as required. Patients needing further assessment will be referred to their patient care team or the Optometry Clinic.

2.3.7. FHME will screen Airmen for physical inactivity and counsel/refer them per PHA business rules.

2.3.8. FHME will educate, counsel, and direct follow-up regarding identified health risks, recommended CPSs , IMR requirements, DLC actions, RILO actions, and/or appropriate clinical follow-ups IAW PIMR/AF Web HA guidance, *the PHA Guide*, and other relevant instructions. Education and counseling duties in this regard will be limited to very brief counseling and education and distributing AFMOA- or ECOMS-approved, PHA-related, patient education handouts. The "Full Patient Report" generated at the end of the AF Web HA will provide Airmen with health education for specific identified risks, however, PHA business rules and other guidance (e.g., the *PHA Guide*) will be used to determine if further counseling is warranted.

2.3.9. FHME will review PIMR for OEH MSE requirements at the time of the PHA. The OEH MSE program is managed separately from the PHA and the status does not affect the PHA. Nevertheless, performing OEH MSEs in conjunction with the PHA is encouraged. If OEH MSEs are to be performed in conjunction with PHAs, and OEH MSE requirements preclude PHA intervals greater than 12 months, PHAs may be performed earlier than prescribed in 2.2.2., 2.2.3., and 2.2.5. to accommodate these requirements. Ref. 2.2.7. for specific guidance regarding flight physicals.

2.3.10. Business rules and local clinical decisions may allow some Airmen to complete their entire PHA remotely (e.g., telephone, video link, email). Other Airmen will require an in-person FHME visit and/or one-on-one provider PHA appointment. An in-person visit to FHME is not strictly required for AD and ANG personnel.

2.3.11. One-on-one provider PHAs will be performed by the Airman's assigned provider unless precluded by extenuating circumstances such as short-notice PHA suspenses, provider deployments, PCS underlaps, and extended provider leaves, TDYs, or illnesses. In these instances, another privileged primary care provider, preferably from the assigned patient care team, will perform the one-on-one provider PHA.

2.3.11.1. PHA providers (AD, reserve, ANG, civilian, or contractor) must have active privileges in primary care, family medicine, internal medicine, occupational medicine, preventive medicine, or flight medicine. (Exception: Independent Duty Medical Technicians (IDMTs) ref. 2.3.12.1., 2.5.4.)

2.3.12. All PHAs for aviators, Airmen on aeronautical orders, and special operational duty personnel must include an in-person interview with a credentialed military flight surgeon with privileges in FOM. PHAs performed by a non-AF flight surgeon (e.g., Navy, Army, or Coast Guard flight surgeons) require review and certification by a base-, ANG MDG-, or RMU-level SGP or, if unavailable, parent MAJCOM/SGP.

2.3.12.1. At some locations, AD IDMTs, IAW local command guidance and/or locally approved protocols within the IDMT scope of care, may provide PHAs to their assigned population. These PHAs will be reviewed and co-signed by the IDMT's physician preceptor. (Exception: PRP/BPRP/PSP Airmen, ref. 2.5.4.2. for further guidance)

2.3.13. The patient care team will use PIMR and the AF Web HA "AHLTA Copy and Paste report" to assess cardiovascular risk in Airmen and counsel them, as needed, to minimize this risk. This assessment will be documented in the medical record. The Cardiovascular Risk Assessment and Management (CRAM) site (**https://kx.afms.mil/cram**) can assist providers in appropriately assessing cardiac risk. A cardiovascular risk assessment involving formal

cardiac risk scoring (e.g., calculating a Framingham Risk Score) and lipid profiles are not universal requirements (i.e. only some Airmen will need cardiac risk scoring and lipid profiles).

2.3.14. During each PHA and IAW AFI 10-203, *Duty Limiting Conditions,* patient care teams (or their surrogates) will review, and if necessary, modify existing AF Form 469s, as well as review the medical record and interval history for conditions that may require an AF Form 469. This review will be documented in the medical record.

2.3.15. As part of the PHA, Airmen may be medically evaluated for clearance to participate in a physical fitness training program to meet fitness requirements IAW AFI 36-2905, *Fitness Program*. This does not replace screening requirements prior to official fitness assessments. Airmen unable to participate in physical activity sufficient to train to meet fitness requirements should be issued an AF Form 469, and an AF Form 422, *Notification of Air Force Member's Qualification Status,* with activity restrictions and exercise prescription.

2.3.16. Airmen who have had an MEB and require subsequent RILOs will have their RILO timelines reviewed during their PHA. While annual RILOs should be coordinated with the annual PHA, the patient care team (or surrogate) must ensure that RILO suspenses are met regardless of an Airman's PHA timeline. Annual RILOs will be coordinated with the MTF Physical Evaluation Board Liaison Officer and forwarded to AFPC or ARC HQ IAW AFI 41-210.

2.3.17. The PHA is "complete" for reporting purposes when the following are accomplished:

2.3.17.1. AHLTA and paper medical record review have been completed.

2.3.17.2. The Airman's patient care team (or surrogate) has addressed AF Web HA results including all critical and priority responses, and has made definitive care plans and dispositions (referral, appointment, etc.) pertaining to these responses.

2.3.17.3. One-on-one provider visit, if required by 2.2.6.1., has occurred.

2.3.17.4. Required CPS, education, and counseling have been scheduled and referrals placed (e.g., referral to non-military provider, specialty clinic, HAWC, etc.). ARC medical components will document when ARC Airmen are advised to see their non-military patient care team for CPS (ref. 2.3.18.1.).

2.3.17.5. Required documentation accomplished by FHME and the patient care team (ref. 2.4.).

2.3.17.6. The provider has reviewed and signed the PHA, including the PHA AHLTA note.

2.3.17.7. The PHA AHLTA note has been accurately coded. PHAs not requiring a one-on-one provider visit should normally be coded with E/M code 99420 (0.24 relative value units). PHAs in conjunction with MEBs and RILOs may require E/M disability exam codes. ARC medical units are not required to code PHA visits.

2.3.17.8. AF Form 1042, if applicable, has been completed and recorded in PIMR at the same time as the PHA.

2.3.17.9. Provider has made a DLC determination, or initiated a diagnostic work-up, if appropriate and/or RILO actions have been completed.

2.3.17.10. The PHA completion date has been recorded in PIMR by the patient care team, if completing the PHA, or FHME, if completing the PHA.

2.3.17.11. CPS results, including laboratory results and completed educational/counseling programs (e.g., tobacco cessation programs), are **not** required to complete a PHA for PIMR and unit reporting purposes.

2.3.17.12. Concerns regarding world-wide duty qualifications should be addressed with an AF Form 469 and not delay PHA completion.

2.3.18. Air Reserve Component (ARC).

2.3.18.1. Reservists and Air Guard members assigned to units with sufficient medical assets will receive their PHAs within their own Reserve or Guard units. When ARC medical resources necessary to complete PHAs are inadequate or unavailable, ARC members are eligible for PHAs and other readiness-related evaluations at other AF MTFs. ARC members need not be in military status to schedule MTF appointments, but must be in military status (active, inactive, or points-only) at the time of the medical service. ARC members are instructed to see their non-military patient care team for clinical services not covered under these provisions. See para. 2.5.7.2. for additional PHA resources for geographically-separated ARC Airmen.

2.3.18.2. Reservists will receive PHAs per the latest AFRC/SGP consolidated program memorandum and *AFRC PHA Guide* (**https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=SGPAFRC**).

2.3.18.3. Guard members and reservists will be notified of any critical or priority findings at the end of their AF Web HA session and will be directed to seek civilian medical care as appropriate. Designated ANG medical personnel will follow-up critical and priority AF Web HA results no later than the next UTA. Reserve ART Team will follow up critical findings immediately (until the Reservist is contacted) and priority findings within one week (until the Reservist is contacted). All attempts to contact the member shall be documented.

2.3.18.4. The Readiness Management Group (RMG) has administrative control over IMAs and compliance oversight. The MTF supporting the IMA's AD unit of attachment is the provider for PHA services and shares responsibility with the RMG for tracking, data entry, and compliance.

2.3.18.4.1. The AD MTF is responsible for AF Form 469/422 actions associated with the PHA and the RMG/SG should be notified of all AF Form 469/422 actions through secure e-mail at **afrc.rmgsg@afrc.af.mil.**

2.4. Required PHA Documentation.

2.4.1. Summary of care note in AHLTA using AFMOA approved templates (e.g., Tri-Service Workflow AIM), or paper record if AHLTA is unavailable, appropriately coded (if applicable), and signed/co-signed by the Patient Care provider (or surrogate).

2.4.2. PHA completion date and provider visit date (if applicable) recorded in PIMR by FHME or the patient care team, if completing the PHA.

2.4.3. Completed AF Form 1042, if applicable.

2.4.4. Signed AF Form 469, if renewed, modified, or initiated during the PHA. The AF Form 422 is only accomplished when needed (exercise prescription, overseas clearance, AFSC retraining, etc). A new AF Form 469 or 422 is not required at every PHA. Refer to AFI 10-203 for further guidance.

2.4.5. Documentation in AHLTA of clearance to begin or continue exercise program and/or completed AF Form 469.

2.4.6. FHME will update the electronic DD Form 2766, *Adult Preventive and Chronic Care Flowsheet* IAW AFPAM 44-155 and AFI 41-210. This update to the DD Form 2766 should include previously undocumented significant medical events, allergies, and surgeries in addition to the current PHA activities. Note: per AFPAM 44-155, the DD Form 2766 should be updated by the provider and/or medical staff at every clinical visit within the MTF. Therefore, at the time of the PHA, necessary updates to the DD Form 2766 should be minimal.

2.4.7. RILO or MEB narrative, as required.

2.5. PHAs for Geographically-separated Airmen.

2.5.1. Geographically-separated Airmen are Airmen not collocated on the same installation nor enrolled to the MTF that administers their PHA (the "Reporting MTF"-see 2.5.2.1. below). MAJCOM/DRU CCs and unit CCs (if applicable) must ensure their geographically-separated Airmen have annual PHAs.

2.5.2. Definitions of Reporting and Supporting MTFs.

2.5.2.1. "Reporting" MTFs are the MTFs accountable to MAJCOM/DRUs for PHA reporting and tracking purposes and are usually collocated on the same installation as the MAJCOM/DRU. Reporting MTFs provide due/overdue PHA rosters to MAJCOM/DRU CCs and oversee PHA processing for geographically-separated Airmen.

2.5.2.2. "Supporting" MTFs are DoD and non-DoD MTFs providing healthcare services to geographically-separated Airmen. These supporting MTFs include, but are not limited to, DoD MTFs (AF, Army, or Navy), and, where no DoD MTF exists, approved TRICARE service providers such as U.S. State Department medical facilities and non-military providers.

2.5.3. Geographically-separated Airmen with local supporting AF MTFs.

2.5.3.1. Geographically-separated Airmen collocated with or near supporting AF MTFs (as determined by MAJCOM/DRU and supporting MTFs) will follow standard PHA instructions and procedures and receive PHAs and follow-up care at these MTFs.

2.5.3.2. Reporting MTF FHMEs will coordinate with supporting AF MTF FHMEs to administer and execute PHAs for geographically-separated Airmen.

2.5.4. Geographically-separated Airmen at locations without local AF MTF support but supported by IDMTs.

2.5.4.1. At GSUs without a local AF MTF but supported by IDMTs, PHA processes shall be directed by the designated IDMT physician preceptor IAW 2.3.12.1. and administered by the FHME at the physician preceptor's assigned MTF.

2.5.4.2. PRP/BPRP/PSP at IDMT-staffed GSUs.

2.5.4.2.1. At GSUs with a PRP/BPRP/PSP mission where the medical support is provided by AD IDMTs, the IDMTs may facilitate the gathering of PHA information but the PHA provider for PRP/BPRP/PSP personnel will be a CMA. Ref. 2.3.1.2.1.

2.5.4.2.2. At GSUs where the CMA is not collocated with the PRP/BPRP/PSP personnel, the CMA will remotely review PHA results while the Airman waits at the GSU medical facility.

2.5.4.2.3. If the remote CMA review cannot be accomplished at the time of the Airman's PHA appointment, the Airman will be suspended from their PRP/BPRP/PSP duties until PHA results are reviewed by the CMA.

2.5.5. Geographically-separated Airmen at locations without local AF MTF or IDMT support.

2.5.5.1. PHA completion of geographically-separated Airmen without local AF MTF or IDMT support will be monitored and overseen by the GSU AF CC (or equivalent) in coordination with the reporting MTF FHME. In situations where no GSU AF CC (or equivalent) exists, the reporting MTF FHME will singularly monitor and oversee PHA completion.

2.5.5.2. After completing the AF Web HA, geographically-separated Airmen without local AF MTF or IDMT support will, at a minimum, be contacted (preferably by phone or video link) by the reporting MTF FHME technician, clinic nurse, or provider to review AF Web HA responses and provide appropriate counseling and education. The MTF should develop a process to maximize efficiency in facilitating GSU PHAs to reduce repeat phone calls to complete the PHA. The SGP and SGH shall identify workflow processes to complete GSU PHAs at the appropriate level of care based on PIMR and AF Web HA reports (e.g., critical and priority responses will be addressed by a credentialed privileged provider, and preventive counseling based on AFMOA- and ECOMS-approved patient education IAW CFETP).

2.5.5.3. PHA-associated exams, counseling, and follow-up care will be scheduled by the member or UHM and be performed at the local supporting non-AF MTF. Some cases (e.g., critical and priority results) will require reporting MTF PHA personnel to confer directly with medical personnel at the supporting MTF to appropriately transfer care and schedule needed services. The reporting MTF/SGP will ensure all care provided by the supporting MTF involving critical and priority AF Web HA responses is reviewed with supporting non-AF MTF personnel within the required time suspenses to ensure appropriateness of care and disposition. See 2.3.17.3. for ARC management of critical and priority responses.

2.5.5.4. Fitness-for-duty and other military-related medical determinations will be made remotely by the reporting MTF/SGP as clinically and administratively appropriate. If this cannot be done, the reporting MTF/SGP, with cooperation and assistance of supporting MAJCOM assets (e.g., PACAF, USAFE), will arrange for this determination to be made at a regional DoD MTF.

2.5.5.5. The Airman will request that documentation of services provided by the supporting MTF be forwarded (faxed, emailed, or mailed) to the reporting MTF FHME for entry into AHLTA and PIMR. Additionally, upon PCS from a geographically-separated location to an AF installation, in-processing will involve a thorough medical record review to ensure pertinent interval care (including PHAs and related services) is entered into AHLTA and PIMR.

2.5.5.6. The reporting MTF/SGP or designee has final signature authority on PHAs performed at non-AF MTFs. Documentation necessary to complete PHAs for geographically-separated Airmen is the same as those listed in 2.4.

2.5.5.7. In lieu of the remote processes detailed in this section (2.5.5.), MTF CCs may choose to periodically send or permanently assign appropriate personnel (providers, technicians, etc.) to larger GSUs to administer PHAs.

2.5.6. In areas where multiple DoD MTFs are located near one another (e.g., the National Capital Area), Airmen may be TRICARE-enrolled at nearby MTFs other than the reporting MTF responsible for administering their PHA. The reporting MTF is still responsible for ensuring these Airmen receive annual PHAs and track compliance. MTFs must develop local instructions and procedures to meet these requirements. Options include, but are not limited to, directing these Airmen back to the reporting MTF to accomplish the PHA, accomplishing these PHAs as "geographically-separated PHAs" as defined in this section (sec. 2.5.), or developing other processes and standing agreements with nearby DoD MTFs to accomplish these tasks.

2.5.7. Air Reserve Component (ARC).

2.5.7.1. ARC members assigned to units without local AF MTF support will complete the AF Web HA will have their responses reviewed by a provider and will, at a minimum, be personally contacted (preferably by phone or video link) to complete the PHA process. The person who contacts the Airman (technician, nurse, or provider) will be determined by the expertise required by AF Web HA responses. Positive AF Web HA responses may require additional documentation from their non-military patient care team. The ART Team (Reserve) or Health Technicians (ANG) will oversee the completion of PHAs.

2.5.7.2. The Reserve Health Readiness Program (RHRP) may be used to provide PHA services for ARC GSUs who lack unit medical resources. The RHRP can provide these services through a nationwide network of non-military providers. Email **rhrp@tma.osd.mil** or see **http://rhrp.fhpr.osd.mil/home.aspx** or **http://www.pdhealth.mil/hss/healthcare_services.asp** for further information about the RHRP.

2.6. Support for Sister Service Members' PHAs.

2.6.1. AF MTFs supporting Army, Navy, Marine, and Coast Guard (CG) PHA requirements will coordinate with applicable Sister Services' unit administrative or personnel support offices to develop standardized PHA processes specifying requirements, notification and scheduling procedures, and required documentation.

2.6.2. Sister Service PHAs will be administered by FHME and referred to their patient care team (or surrogate) as directed by locally-developed processes. FHME will be staffed IAW 1.2.18.2.4., accounting for these additional Sister Service members.

2.6.3. Sister Service-specific PHA guidance listed below are general guidelines and subject to change by the respective Services.

2.6.3.1. Soldiers are notified their PHA is due via the Army Knowledge Online (AKO) website. They will print their PHA paperwork from AKO and bring it to their appointment. At a minimum, the AF MTF will provide PHA services, complete necessary paperwork, and document the visit in AHLTA. FHME will also document PHA services in the ASIMS Web App if the soldier's information can be retrieved, viewed and edited in ASIMS. ASIMS automatically transfers common data elements (PHA date, e.g.) of the soldier's data to the Medical Protection System (MEDPROS) for documentation. For PHA-related requirements or examination findings that cannot be documented in the ASIMS Web App (or cannot be viewed or edited), FHME can directly document PHAs (and other IMR or OEH MSE services) in MEDPROS or provide soldiers with printed documentation of the completed PHA paperwork that they can hand-carry to their unit personnel clerk for entry into MEDPROS.

2.6.3.2. Navy or Marine PHAs will be documented in AHLTA using the Navy/Marine Corps PHA AHLTA template found in the enterprise folder. If AHLTA is not available, the form NAVMED 6120/4 (03/2008*), Periodic Health Assessment,* will be used. This form and other PHA guidance are available at **http://www.med.navy.mil/pages/default.aspx**. Sailors and Marines will hand-carry a copy of the PHA paperwork to their personnel support office. Sailors and Marines are responsible for ensuring their respective health services personnel enter their PHA completion date into the Medical Readiness Reporting System (MRRS) for IMR reporting purposes.

2.6.3.3. CG Form 6150, *U.S. Coast Guard Periodic Health Assessment,* is used to document CG PHAs. This form and CG PHA guidance can be found at **http://www.uscg.mil/hq/cg1/cg112/cg1121/PHA_med.asp**. CG PHAs will be documented in AHLTA using the Navy/Marine Corps PHA AHLTA template found in the enterprise folder. CG members will hand-carry a copy of the PHA paperwork to their health record custodian. CG members are responsible for ensuring their respective health services personnel enter their PHA completion date into the MRRS for IMR reporting purposes.

2.6.3.4. If permitted by Sister Service instructions, FHME will use AF processes including the AF Web HA, to accomplish Sister Service PHAs.

2.6.3.5. FHME will serve as a repository for Sister Service-specific forms, instructions, guidance, and expertise.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFI 48-145, *Occupational and Environmental Health Program*, 15 Sep 2011

United States Preventive Services Task Force Guide to Clinical Preventive Services, available at **http://www.preventiveservices.ahrq.gov**.

Adopted Forms

DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 469, *Duty Limiting Conditions Report*

AF Form 1042, *Medical Recommendation for Flying*

AF Form 847, *Recommendation for Change of Publication*

CG Form 6150, *U.S. Coast Guard Periodic Health Assessment*

NAVMED 6120/4 (03/2008*), Periodic Health Assessment*

Abbreviations and Acronyms

AD—Active Duty

AF—Air Force

AF WEB HA—Air Force Web-Based Health Assessment

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFPAM—Air Force Pamphlet

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AHLTA—Armed Forces Health Longitudinal Technology Application, the DoD Electronic Medical Record

AKO—Army Knowledge Online

ANG—Air National Guard

ARC—Air Reserve Component

ART—Air Reserve Technician

ASIMS—Aeromedical Services Information Management System

BMI—Body Mass Index

BPRP—Biological Personnel Reliability Program

CAC—Common Access Card

CC—Commander

CFETP—Career Field Education and Training Plan

CG—Coast Guard

CMA—Competent Medical Authority

CPG—Clinical Practice Guideline

CPS—Clinical Preventive Services

CPT—Current Procedural Terminology

CRAM—Cardiovascular Risk Assessment and Management

DLC—Duty Limiting Conditions

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DRA—Deployment Resiliency Assessment

DRU—Direct Reporting Unit

ECOMS—Executive Committee of the Medical Staff

E/M—Evaluation and Management

FHME—Force Health Management Element

FOM—Flight and Operational Medicine

GPM—Group Practice Manager

GSU—Geographically-separated Unit

HAWC—Health and Wellness Center

HCI—Health Care Integrator

HQ—Headquarters

IAW—in accordance with

IMA—Individual Mobility Augmentee

IMR—Individual Medical Readiness

KX—Air Force Medical Service Knowledge Exchange

MAJCOM—Major Command

MDG—Medical Group

MEB—Medical Evaluation Board

MEDPROS—Medical Protection System application

MPF—Military Personnel Flight

MRRS—Medical Readiness Reporting System

MSME—Medical Standards Management Element

MTF—Medical Treatment Facility

NDAA—National Defense Authorization Act

OEH MSE—Occupational and Environmental Health Medical Surveillance Examination

OPR—Office of Primary Responsibility

PA—Privacy Act

PCS—Permanent Change of Station

PEBLO—Physical Evaluation Board Liaison Officer

PHA—Preventive or Periodic Health Assessment

PIMR—Preventive Health Assessment and Individual Medical Readiness application

PME—Professional Military Education

PRP—Personnel Reliability Program

PSP—Presidential Support Program

RHRP—Reserve Health Readiness Program

RILO—Review in Lieu of Medical Evaluation Board

RMG—Readiness Management Group

RMU—Reserve Medical Unit

SG—Surgeon General

SGH—Chief of the Medical Staff

SGP—Chief of Aerospace Medicine

TDY—Temporary Duty

UHM—Unit Health Monitor

USPSTF—United States Preventive Services Task Force

UTA—Unit Training Assembly

Web HA—Web-based Health Assessment